Ankle & Foot Specialists

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Diplomate: American Board of Foot & Ankle Surgery

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Patient Information

Patient Name: _____ Date of Birth: _____ Gender: (circle one) Male Female

Ethnicity: (circle one) Hispanic Non-Hispanic Race:_____ Language Spoken at Home: _____

Social Security #:_____ Drivers License # _____

Address:_____

City: _____ State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Ext: _____ Cell Phone: _____

Preferred Communication: (Circle one) Home Phone Work Phone Cell Phone

Email Address: _____

Employer Name: _____ Occupation: _____

Marital Status:_____ Spouse's Name_____ Spouse's Cell Phone: _____

Parent's Name: (if minor) _____ Parent's Cell Phone: _____

Patient's Primary Care Physician: _____ City:_____ Phone #: _____

Emergency Contact: _____ Relation to Patient:_____ Best Contact #: _____

Insurance Information

Primary Insurance	Secondary Insurance
Policy Holder:_____	**Policy Holder:**_____
DOB: _____ **SS#:** _____	**DOB:** _____ **SS#:** _____
Relation to patient: _____	Relation to patient: _____
Insurance Company: _____	Insurance Company: _____
Address: _____	Address: _____
Phone #: _____ Effective Date: _____	Phone #: _____ Effective Date: _____
ID #: _____ Group #: _____	ID #: _____ Group #: _____

How did you hear about our office?

PCP: _____ Patient:_____ Insurance Book Internet Phonebook Other:_____

By signing below, I hereby authorize Ankle & Foot Specialists to treat the above patient. I also authorize payment of medical benefits, and release of correspondence and/or medical records to other medical providers involved in your care. I have read and understand Ankle & Foot Specialists' financial policy.

_____ _____ _____

Signature of Patient or Responsible Party | Patient Name (print) | Date